AZ HIPAA Medicaid Consortium

April 9, 2003
2:00 PM to 4:00 PM
AHCCCS 701 E. Jefferson St. – 3rd Floor - Gold Room

Meeting Hosted By: Lori Petre, AHCCCS

Attendees:

ADHS	APIPA	NEAZ
Jeannette Heller	Tammy Klein	Russ Johnson
Thomas Browning	David Wormell	Luan Lin
Brian Heise		
Luis Vasquez/ CJ Major	BHS	Pinal LTC
	Janice Hippe	Susan Murphy
AHCCCS		
Pat Spencer	CIGNA	PHS
Terri Greene	Jack Corcoran	Robert Imperio
Patti Goodwin		Mark Hart
Nalini Mukerji	DES	
Deborah Burrell	Marcella Gonzalez	UFC
Lydia Ruiz	Major Williams	Eric Nichols
David Shelburg	Aidan Frazier	Kathleen Oestreich
Brent Ratterree	Nicole Yarborough	John Valentino
Kathy Taylor-Laws		
Phyllis Tracy	HCA	Verizon
Margo Himes	Stacy Kruse	Marsha Solomon
Nancy Mischung	Gus Moron	
Bruce Jameson	Mike Uchrin	Yavapai County
Kyra Westlake		David Soderberg
Linda Barry	HCSD	
Frank Straka	Michael Wells	
Karen Kradle		
Sandy Biggs	I.H.S.	
Kathy Bezon	Charolett Melcher	
Gloria Collins		
	MCP & Schaller Anderson	
	Anne Romer	
	Art Schenkman	
	Cathy Jackson-Smith	

1. Welcome (Lori Petre)

Welcome to everyone.

2. Project Schedule Update (Lori Petre)

We are on track with our dates.

- Coding finished for 834/820
- Unit testing complete
- We are finishing Final Validation of the acceptance test region and we will begin the system and integration test of the 834/820 transactions.
- 997 will be discussed today

3. Implementation/ Contingency Planning Update (Tom Walsh)

We are putting together a plan for implementation that covers the detail steps that it will take to implement the transactions. Part of this plan is contingency, if we cannot implement one of the transactions as on schedule, or if some of the plans cannot implement on schedule, we are developing some of the fall back positions on each of the transactions.
By next meeting there will be more to share on contingency.

4. Local Codes Update (Brent Ratteree)

We have approximately 140 local codes identified; there are a few we are waiting to be returned from the National panel.
We have a number of codes that have been already mapped. There was distribution earlier in the year listing what those codes would be.
We anticipate having 60% of the codes finalized and approved by executive management by the end of this month.

There are some other codes that we have published to complete some rate analysis on. These are targeted for May or first part of June.

There are 25-35 local codes we are waiting on the National Panel to resolve. They have not resolved yet but have promised the Medicaid Workgroup that this will be completed by the end of this month. Once this is provided we

5. Follow-up on 834/820 Presentations (Mary Kay McDaniel)

One follow-up item was Custodial Parent information availability. We have not identified who has custodial parent information that could be used.

We have not found a source that is reliable and provides the accurate custodian information.
We will continue to make phone calls and track this information. Once this information is tracked down it will not be available for 10/16/03.

A request was sent to X12 to add the AA and AE codes to add as maintenance reason codes. It will be presented in front of the X12 committee at the June 2003 session.
A packet will be provided and presented to be voted on, then approved for the 4070 of the 834. In the interim, the codes will continue to be carried on 2300 line.

Action Item: Small files to be provided for test are in test plan. We will let you know by next week if this will be feasible.

Action Item: CRS/ BHS we have additional work to do, 820 document will be presented separately to them.

Q: Any resolution on the dial in to VPN losing local area connections for IT clients.
A: Suggestion: Call the Help Desk (602) 417-4451, a ticket will be handed in to Network. There are other options available.

Q: What will you or can you have as a back up plan for not receiving or accepting a transaction when we send it to you.
A: We will discuss this during the 997 conversation.

Overview of 820 transaction (Tom Walsh)

Handout is an overview of the HIPAA 820 transaction.
The 820 transaction is by payment. Each payment, check, transfer has an 820 transaction. We need to capture all the information in that transaction.
The transaction is made up of the Header, detail, and Trailer information.

Header: Contains the sending bank, receiving bank accounts, check numbers, reassociation key of the check number, premium receivers identification, coverage period (earliest and latest date of all the transactions you will be receiving in the detail). It also has premium payer, premium receiver name, id, and address.

Detail: Reflects the detailed basis for the payment. Two types of records exist: Organization summary remittance. Which are lump sump payments, not related to individuals. Containing: Sanction payment, lump sum settlements, etc. Showing up in the second segment of the transaction.

The third segment is the individual remittance.
This Contains: names, premium remittance detail, and adjustments related to individual payments.

The detailed segments are followed by a trailer.

What happens today for capitation payments is:
AHCCCS generates a roster with enrollment and payment information. With the 834 the payment information will not be included, we need to place this information on the 820.
When the roster is generated the system creates a payment transaction that goes to the financial system. A voucher number is created, then invoice number, and then it sits till a payment cycle is run and picked up issuing one check for many transactions.

In addition Finance staff can issue lump sum adjustments manually, lump sum payments, partial payments, etc.

We have put together some examples on how this would work.

Transaction examples:

Example 1:
Standard premium payment transaction:

$3,000 paid for four members. No recoveries or adjustments.
This has standard header records and each of fields that we plan to use.

Financial Information:
Total premium payment amount has to balance with all the records to be showed.
Payment method, Qualifiers, accounts, receiving bank and receiving accounts.
Transaction date, it applies to entire payment.

Reassociation record:
Originating company identifier (AHCCCS tax id).

Receiving info:
Health plan Id

Coverage dates:
The second format statement
Third period covered by this statement

1000A:
Shows receiver name and address, tax id, payer name and address.

1000B:
Shows payer name and address.

Q: Would this have the PPC payment? Even if it goes back a year or two.
A: Yes, it would show that date also on the header record.

Next page would be summary transactions that do not exist in this scenario.

<u>Next is the Detail, Individual Remittance:</u>
This describes the information on who the payments are being made.

2000B
Individual who we are dealing with.
2100B
Name of person, last four fields will not be used.
2300B
Detail for payment.
Important: Insurance remit payment number with four different fields.
Contract type, county, cap rate code, voucher id. Voucher id can tie payment record into 834.
Payment action code will not be used.
Premium payment amount
Date time qualifier
Format qualifier tells you the format
Coverage period tells what period this transaction is for. This will help identify the period you are dealing with.

Then all the individual payment amounts in this detail will balance to the header amount of $3,000 on check amount.

Example 2:
Premium payments of $2,300 for three members; recovery of $300 previously paid in error for a member; lump sum sanction recovery of $500.

Header:
Total premium amount is $1,500

Summary remittance detail:
Tells you the invoice number, payment on account with negative number on adjustment.
Detail on the 2nd record is a negative recovery rather than a positive.

This will be sorted by individual.
The invoice itself will be the adjustment.

Example 4:

Same four members with a lump sum settlement, but only partially paying this amount.

At the second table we begin to use the summary adjustment fields.

2300A:
We have the invoice number and a partial payment. Paying $1,500, even though the billed premium amount is $2,000.
We will show payment on invoice and then under Summary Adjustment 2320A, we will show you that adjustment amount. The code H6 indicates partial payment.
We agreed on $2,000, withholding $500 and are paying $1,500. This is the second balancing requirement on the 820.
Plus $3,000 cap, etc. Then it all balances to the header.

Q: Is it expected to have a 1:1 relationship 834/820
A: No, you could have multiple rosters for one payment. The only way to tie back the transactions is by voucher number.

Changes to name, etc. that have no financial impact, will not have an 820 transaction.

The Kick payments will not show up on rosters but on will show up on 820.

Q: Will the 834/820 come at the same time?
A: They will be separate files and come at different times.

Q: Will there be weekly payments?
A: Yes

6. Companion Documents Update (John Peters)

Since our last meeting we placed the 834/820 companion guide on the AHCCCS web site and received input internally and externally. A similar document was created for HI, request for changes have been received.

We have a specific process describing how data is used.
I have been working on 837 companion guides affecting providers more than plans.
There are many things to keep in sync within Claims and Encounters.
Action Item: A draft Companion document version will be put out on the 837 next week.
Result: The document has been placed on the Web site as of 04/16/03

7. Discussion of 997 Transaction (Mary Kay McDaniel)

Outbound Flow document:
Data will be extracted from PMMIS/HPMMIS. A file will be sent to the Mercator software.
Within Mercator there are 3 levels:

- Applications Manager
- Compliance checker
- Commerce manager

Compliance checking is done on outbound and inbound transactions.

The theory is that AHCCCS should never send a transaction that is not 100% HIPAA compliant.

The Applications Manager does the actual translation piece.

Type 1: Integrity testing is the bottom line X12 testing.
Type 2: Do we have the right amount of loops.

Type 3: Balancing
Type 4: Situational – there are ambiguities in the implementation guides. Who is going to define an inpatient claim? Can we use Place of Service? No since Place of Service is not an industry definition.

After the transaction has gone through Applications Manager, Compliance Checker, then Commerce Manager sends it out the door.

AHCCCS would like a TA1 from the plan indicating that it was received.
We would like to assume that if we do not receive a 997 back that means it was clean and it worked.

Q: Will the application map do logical data validation?
A: No, the application map assumes that what it received from PMMIS is correct.
The application map within Mercator validates that a field exists and moves it. This is the translator piece of Mercator, doing the mapping.

Compliance Checker goes through and says that this is an 834 and you need to be in this format, we cannot have more than 5 REF segments in a particular loop, etc.
Level 1 and 2 are also handled here and they say it has to be an x12 compliant transaction to go out the door.

We are going to request during our testing phase to send a sequence number on each transaction line. It is technically non compliant but provides comfort that information is in the right sequence order under testing.
The intent is to always have everything in the right sequence for production, the sequence number will not move over to production.

AHCCCS will like to see the following Acknowledgements:
TA1 = send always saying you accepted/received the file. This item can be sent by itself without any other interchange.
997 = send only if there is problems

Q: What if we do not have the ability to produce a 997 only on a failure?
A: If there is an issue with this, we will need to know.

Q: Will this work both ways.
A: Yes, see the next flow.

<u>Inbound flow document:</u>

The 837 goes out and sits on the FTP server, we pull it across using Commerce Manager.
TA1 is processed.

There is a current process where we pick up a file, make a duplicate, and put it in an outbound file so vendors know we received the file. We were hoping to avoid this process.

Q: We are communicating to the plans on the out folder on the FTP server. The Plans are going to respond to AHCCCS through their IN folder, is this correct?
A: We can check every 5 min, every hour, or not check during high volume times.
Maybe check in the morning, lunch and COB and then every hour at night. (Timing has not been determined.)

AHCCCS would welcome any suggestions.

We would communicate we have file with TA1.
It will go into Commerce Manager doing a type 1 and type 2 edits, if failed a 997 would be returned.
We will have a 997 returned at the lowest level possible. If we are not able to go any lower we will respond at the ST SE level.

The item that goes to Commerce Manager passing levels 1 and 2, a report will be sent to individuals saying what passed and what failed, then it goes to Compliance Checker, checking levels 1 through 4.
For level 3 edits the only transaction identified to convey out of balance information is an 824. The 824 is not a mandated transaction. If we cannot get it through the translator then how can we communicate it?

Q: Is it possible to get a 997 for 1-2, 824 for a 3, and another 997 for a 4?
A: No, if you pass a 1,2 you will not get a 997 for the 1 and 2. If you fail at 3 the item will not go on. It will stop at the point of failure.

Health plan: We would prefer that you would return every edit.
Answer: If we pass every type of edit, and you fail at 1, then we go ahead and do 2, 3 and 4. Then we open you to the issue of having a 997 for the 1, 997 for 2, 824 for 3 and a 997 for the 4.
Would the plans want that situation?

ISA flow document:

Q: Where are we going to be rejecting?
A: On incoming transactions we will reject at the ST SE for the interchange.

You will need to be able to read every 997 and figure out what is wrong with that particular claim and only send back that particular claim. You must have a process on the outside of your translator to do this.
Health plan: If I reject at the claim level. I do not want to send 1000 and all reject, but pay for every claim that you can and resolve the one that does not pay after.
Answer: The issue for other folks is that once the batch is sent out the door, sending 50,000, 450 are wrong. You will need to identify the individual claim that is wrong. For other plans this is difficult. We are hearing that it is easier to send back the entire ST SE file rather than the individual claim within that ST SE.

However, initially there has to be that handhold why something was rejected.

AHCCCS is reviewing rejecting at the ST SE level for incoming transactions. Outgoing 834s, AHCCCS suggests health plans reject at the interchange level.
The reason: AHCCCS processes an entire file. If there is an error the entire transmission will be returned at the Interchange level.

The concern is that if there is a problem in one ST/SE somewhere, it can have an effect on others.

TA1 has nothing to do with the data content. We would expect a 997 for each functional group that is sent out if it was in error. Operations are also open 24 hours if a phone call is preferable.

Today, the plan is to send out one functional group type, per interchange, per health plan id.

Mercator can reject at three different levels. We can do this by functional group type.

Q: How do we relate the ST SE and Interchange back?
A: In Commerce Manager, it does a carry over from some of the higher level loops down.
Where we will have problems if we cannot get it passed the Applications Map. We are still working on this issue.

Q: Have you looked on how to handle this in the next Mercator release?
A: At this time AHCCCS is not anticipating doing 5, 6, and 7's in Mercator. We are getting this data through the PMMIS application, these are external code sets, HCPCS, ICD9's, etc.

Q: How will you notify us of the code set?
A: If it is an external code set error it will process through the application like it does today. If it is a bad HCPCS you will get it back on the 835. If it is a code set specific to the Implementation Guide, such as G1 for the prior auth, referral number, these are handled as a type 2.

Health plan: I would like to see a 997 communication back to us that the file was accepted.
Answer: We will review your request.

Q: Encounter load process, will it change?
A: We do not know how much will change. The details have not been discussed.

Q: Will you be able to notify what was accepted from the load process?
A: Yes, no news is good news. We understand that you want a response instead of no news.
Action: We will look at a notification of what was accepted from the load process, since you have a preference for a 997.

Q: There is always a question about what happens if something happens in the middle of the night, who will receive that phone call?
A: This is an item in the contingency plan. No decisions have been made on how to staff.

Q: Are we going to continue with the monthly cycle for encounters? There has been some conversation about changing from a monthly cycle.
A: That process is still being looked at for change. A timeframe cannot be given at this time.

Q: Group of very small transactions set.
A: From the AHCCCS Inbound perspective we will reject the ST SE interchange. One check is equal to one ST SE.
For the bigger health plans the week that the monthly is included your file will be large. An 820 can only have one check equal to one ST SE.
The whole interchange will be one ST SE.

Action: We will send a follow up question regarding the acknowledgement transactions, requesting some input prior to our next consortium meeting. Nancy's staff has to complete this and cannot wait.
Result: Email sent 04/14/03 requesting responses.

The translator schedule and the application site does not have to be the same. We will be looking at scheduling times and look for windows to process.

8. Group 1 – Testing Overview (Lori Petre)

Calendar attached in package.
Outlines the approach to Group 1 testing. Primarily being 834/820 testing although we start 270/271 testing during the same window, we are going to allow 270/271 to occur through out both windows of the testing period.

We have talked about test environment validation; acceptance testing for AZ starts tomorrow. HI will begin next week.

Our current approach:
When we begin pilot testing we will run daily's every day, monthly's on the schedule when they would be run. Ideally what we have loaded into the environment as of the day before 05/05 is full volume recipient just like production and an input processor so you can get a parallel test out of this.

Q: Are there any concerns about the amount of data you will be getting as a result of this approach?
A: No comments made.

Group 2 testing will not need full volume encounters but we had you send full volume recipients.

Daily to run every day, Capitation will run as in production schedule, monthly on monthly schedule. During this window you can pick up three monthly's if you need them or, as many daily's when you are ready to pick them up.

Q: How long is the database data?
A: We will try to get them to remain in the folders as long as possible.

Capitation rolls and pays weekly.

What we want this environment to do is run and act like production.
Everything should happen like it does in production.

If you have other needs that you need out of this testing please let us know, we can create scenarios on-line to assist with this test.
This also means if we are running all current daily, weekly, monthly process. You will have a good feel for what reports you will continue to get and be able to see what reports you need replaced.

We need to decide at which points we want to test the confirmations. We will advise if we need to test the acknowledgements separately.
We cannot test until development is completed on this subject and before development is began we need your consensus.

If your process is already set up to send those confirmations back you can send them and we just will not pick up until we are ready to do so.

There is a 4050 997 that has more flexibility than a 4010 997.
We will need to be all in agreement.

Action Item: We will go back and check the flow regarding the 997.
Result: Corrections have been made and emailed update to Consortium members on 04/14/03.

Action Item: Those who have volunteered for pilot testing we will be contacting by later next week.

9. Problem Reporting Forms and Instructions (Lori Petre)

We are also going to use a Problem Tracking form to identify problems that you can send in. We will track these documents and a formal response will be sent. There is a new Testing bookmark on the HIPAA web site. The Problem Report form and Instructions has been placed there.

New Testing Coordinator will be Lydia Ruiz.

Q: Is the current FTP process documented?
Action Item: We can make the documented FTP process available. Nancy will take this task.

Q: Is there a solution for the VPN issue, it cannot pick it up with Connect direct, it tunnels between two points?
A: Call a ticket to help desk and talk to Network services. Limitations were identified but other options are available.

Q: If we do not intend to use the 270?
A: If there are some transactions that you will not test or use, please advise. You will not be required to test them.

Q: Do we know which translator each health plan has?

Action Item: Lori will check on what Tina had documented in reference to the translators that each plan has.

Clarification:
What we are coding for at AHCCCS are your versions of all your transactions up to and including the approved Addenda.
When you begin testing with us our maps are coded up to the approved Addenda. Therefore, if you have not coded including the approved Addenda this will be one of our points of failure.
If this is a problem we need to know about it sooner rather than later.

9. Other Items (Group)

Data Certification (Brent Ratteree):

Balance Budget Amendment:
There was a change in this packet that affects how the plans will send information to us.

Go to pg. 2. There are currently two forms for encounter purposes that you submit and have on file with us so you can transmit encounter data.
One being the Encounter Submission Notification form, saying you will send all the data and will make sure your submissions are correct.
The other form is the Data Interchange Agreement, saying you will follow all the rules and policies when sending data to us.
These forms will change slightly, it will include a few phrases, such as, the data submitted is accurate complete and truthful to the best of your knowledge.

On pg. 3, subpart H, requires that any MCO's that submit information to a state agency must comply with all the subpart requirements. The certification includes enrollment, encounter, other data, or documents you may send to us.

In section 438.604, the data must be certified include but not limited to enrollment information, encounter data and other information required by the state and contain in contracts, proposals, and related documents.

It also requires certification requirements by source, content and timing.
On pg. 4, the source means it must be certified by CEO, CFO or designated individual. That designated individual must be a direct report to the CEO or CFO.
The Content says that for the best of your knowledge and belief that what you are sending to us is accurate and truthful.
The Timing piece says that the data sent must be submitted concurrently with certified data. So when you send a data file the Certification form must be sent as well. This says it is accurate complete to the best of your knowledge and must be signed by one of those individuals.
A Certification Form has been developed and approved by two legal council members.
Action Item: We will send this Draft document of the Certification Form out along with the minutes.
Result: Attached to the minutes.

There are two proposals to make this document electronic.

Two options:
Electronic submission of certification form.
Fax submission of certification form. We will need a pause in the process to verify the signatures.

Review: on pg. 6. Information you submit to us must comply with subpart H, be certified, and submitted concurrently, two options will be available.

Q: Is it possible to establish a certificate that AHCCCS in-houses, through FTP?
Action Item: We need to finalize B2B requirement handling for certification.

Statement: There is usually a protocol layed out for every time that we do a process. You are certifying that a process that generated this data is approved and correct. This will help with the timing issue.

It is the data itself not the process that needs to be certified.

Q: Is this specifically AZ?
A: No, national. There are some state in the Medicaid listserv that have been discussing this, so far we are the only ones trying to make an option of making this an electronic process.

Q: What is the effective date?
A: August 2003, however the enforcement may not be as strict, we could possibly roll this into our HIPAA stuff.

We have proposed that this form not be included in the HIPAA transactions because it is not specific to a transaction. This refers to only the information you send AHCCCS.

The Federal register 67 #115 published, Friday, June 14, 2002, pg. 41112, subpart H. can be referenced for a copy of what we discussed today.

Q: Have you look at the 996 transaction?
A: No

Per Mary Kay McDaniel, AHCCCS is reviewing the 864.

The HL7 group, sent a letter to secretary Thompson regarding claim attachments.
They are recommending that HSS holds off on publishing any NPRM because they want to move to client document architecture (CDA). They could have the proposal to HHS and CMS in a matter of a few months and finalize by January of next year.
Action Item: The HL7 group letter will be sent with the minutes.
Result: The letter was emailed 04/11/03.

Last item in packet is a proposed meeting schedule.

Meeting adjourned.